Employee Benefit Highlights

NorthPort FLORIDA

2021-2022

Contact Information

	Employee Benefits Coordinator		Phone: (941) 429-7132 Email: rluttkus@cityofnorthport.com
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) Email: support@mybentek.com www.mybentek.com/cityofnorthport
	Medical Insurance	Aetna	Customer Service: (866) 983-0108 www.aetna.com
	Prescription Drug Coverage & Mail-Order Program	CVS Caremark	Customer Service: (888) 792-3862 www.aetna.com
	Telehealth	Teladoc	Customer Service: (855) 835-2362 www.teladoc.com
HSA	**Health Savings Account**	HSA Bank	Customer Service: (800) 357-6246 www.hsabank.com
	Dental Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	EyeMed	Customer Service: (866) 939-3633 www.eyemed.com
FSA	**Flexible Spending Accounts**	P&A Group	Customer Service: (800) 688-2611 www.padmin.com
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4662 www.mynylgbs.com
	Voluntary Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4662 www.mynylgbs.com
	Voluntary Short Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4662 www.mynylgbs.com
	Voluntary Long Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4662 www.mynylgbs.com
	Employee Assistance Program	Cigna Behavioral Health	Customer Service: (877) 622-4327 www.mycigna.com
	Supplemental Insurance	Trustmark	Customer Service: (888) 254-1093 www.trustmarksolutions.com
		Transamerica	Customer Service: (888) 254-1093 www.transamericaemploymentbenefits.com
	Identity Theft Insurance	LifeLock	Customer Service: (800) 543-3562 www.lifelock.com
	Pet Insurance	Nationwide Pet Insurance	Customer Service: (877) 738-7874 www.petinsurance.com/cityofnorthport

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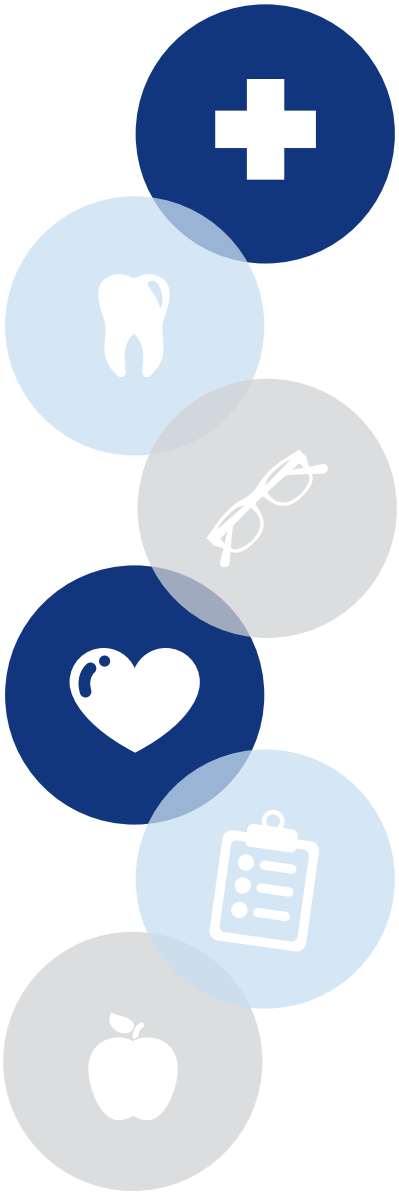


This booklet is merely a summary of benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

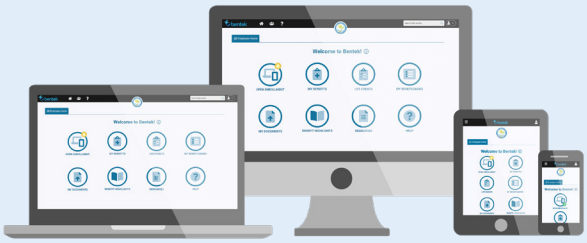
Introduction

The City of North Port provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the City's Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Employee Benefits Coordinator for further information.

Online Benefit Enrollment

The City provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Life Events.

Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefit plans, and view and print an outline of benefit elections for employee and dependent(s). Employee also has access to important forms and carrier links, can report Qualifying Life events and review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/cityofnorthport**
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-Bentek (523-6835) or email Bentek Support at support@mybentek.com Monday through Friday during regular business hours 8:30am - 5:00pm.

To access Employee Benefits Center online, log on to:
www.mybentek.com/cityofnorthport

Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*

Group Insurance Eligibility

The City's group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the City's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the first of the month following 30 days of employment. For example, if employee is hired on April 11, then the effective date of coverage will be June 1.

Separation of Employment

If employee separates employment from the City, insurance will continue through the end of month in which separation occurred. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse and/or dependent child(ren) of the participant or spouse. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A stepchild
- A newborn child (up to the age of 18 months old) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Dependent Age Requirements

Medical, Dental and Vision Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent may continue to be covered on these plans to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student; and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

Please see Taxable Dependents if covering eligible over-age dependents.

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if:

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group medical plan; and
- The dependent has been continuously insured

Proof of disability will be required upon request. Please contact the Employee Benefits Coordinator if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under employee's medical, dental and vision insurance plans may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, imputed income for the value of the applicable adult child's coverage for the coverage period must be reported on the employee's W-2 for that entire tax year and will be subject to all applicable Federal, Social Security and Medicare Taxes. Imputed income is the dollar value of insurance coverage attributable to covering each adult dependent child. Contact the Employee Benefits Coordinator for further details if covering adult dependent child who will turn age 27 any time during the upcoming year or for more information.

Imputed Income Value

26 Payroll Deductions - Per Pay Period Cost

Plan	Income Value
Aetna Select Plan	$192.57
Aetna POS II Plan	$193.36
Aetna POS II with HSA Plan	$186.90

Please Note: *There is no imputed income if adult dependent child is eligible to be claimed as a dependent for Federal income tax purposes on employee's tax return.*

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, contributions to Health Care and Dependent Care Flexible Spending Accounts (FSA), and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code and are pre-taxed to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependent(s) experience(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with other parent or legal guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing or becoming eligible for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)

IMPORTANT NOTES

If employee experiences a Qualifying Event, the **Employee Benefits Coordinator must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event". If approved, changes may be effective the date of the Qualifying Event or the first of the month following the Qualifying Event. Newborns are effective on the date of birth. Qualifying Events will be processed in accordance with employer and carrier eligibility policy. Beyond 30 days, requests will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements.

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is provided as a supplement to this booklet being distributed to new hires and existing employees during the Open Enrollment period. The summary is an important item in understanding employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From:	Employee Benefits Coordinator
Address:	4970 City Hall Blvd. North Port, FL 34286
Phone:	(941) 429-7132
Email:	rluttkus@cityofnorthport.com
Website URL:	www.mybentek.com/cityofnorthport

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting the Employee Benefits Coordinator.

If there are any questions about the plan offerings or coverage options, please contact the Employee Benefits Coordinator at 941-429-7132.

Other Available Plan Resources

Aetna offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please contact Aetna's customer service at (866) 983-0108, or visit www.aetna.com.

Telehealth

Aetna provides access to telehealth services as part of the medical plan. Teladoc is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. Registration is required and should be completed ahead of time. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues. Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with telehealth, such as:

- ✓ Sore Throat
- ✓ Headache
- ✓ Stomachache
- ✓ Fever
- ✓ Cold And Flu
- ✓ Allergies
- ✓ Rash
- ✓ Acne
- ✓ UTIs And More

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please contact Aetna.

Aetna
Teladoc | Customer Service: (855) 835-2362 | www.teladoc.com

Aetna Behavioral Health AbleTo

AbleTo is a convenient program to help manage life's changes. Aetna has teamed up with AbleTo, a leading behavioral health care provider, to offer a convenient 8-week program offering counseling or coaching by phone or video. This benefit is provided through the Aetna Medical plan and is a tailored care experience providing support from a therapist and coach. It makes it easy to get the help you need, when you need it.

The plan offers online virtual or phone consultation anytime or anywhere providing members private and confidential support conveniently and saving members travel time.

- Digital Emotion Health Programs
- Motivational and Behaviorial Coaching
- Licensed Cognitive Behavioral Therapists

The goal is to make it easy for members to complete the program and gain control of life's situations and work toward healthy changes. For more information call AbleTo at (844) 330-3648.

Aetna Behavioral Health AbleTo
Customer Service: (844) 330-3648 | www.aetna.com

Medical Insurance

The City offers medical insurance through Aetna to benefit-eligible employees. The costs per pay period for coverage are listed in the premium tables below and a brief summary of benefits is provided on the following pages. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Aetna's customer service.

Medical Insurance – Aetna Select Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost 100% Completed Incentive & Non-Tobacco User	Employee Cost Completed Incentive or Non-Tobacco User	Employee Cost Without Completed Incentive and Tobacco User
Employee Only	$0	$27.17	$57.92
Employee + Spouse	$160.53	$187.70	$229.04
Employee + Children	$132.02	$159.19	$198.65
Employee + Family	$325.55	$352.71	$404.95

Medical Insurance – Aetna POS II Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost 100% Completed Incentive & Non-Tobacco User	Employee Cost Completed Incentive or Non-Tobacco User	Employee Cost Without Completed Incentive and Tobacco User
Employee Only	$1.22	$28.39	$59.23
Employee + Spouse	$163.06	$190.23	$231.74
Employee + Children	$134.32	$161.49	$201.11
Employee + Family	$329.43	$356.60	$409.09

Medical Insurance – Aetna POS II with HSA Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost 100% Completed Incentive & Non-Tobacco User	Employee Cost Completed Incentive or Non-Tobacco User	Employee Cost Without Completed Incentive and Tobacco User
Employee Only	$0	$26.37	$56.21
Employee + Spouse	$84.98	$111.35	$146.80
Employee + Children	$69.89	$96.25	$130.71
Employee + Family	$172.34	$198.71	$239.93

Dependents Age 26-30

If covering an over-age dependent (a dependent child who will reach age 27-30 during the year), please refer to the "Taxable Dependents" section on page 2 as employee may be subject to additional income tax.

Aetna | Customer Service: (866) 983-0108 | www.aetna.com

Aetna Select Plan At-A-Glance

Locate a Provider

To search for a participating provider, contact Aetna's customer service or visit www.aetna.com. When completing the necessary search criteria, select **Aetna Select (Open Access)** network.

Plan References

**LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Aetna. When using a lab other than LabCorp or Quest, please confirm they are contracted with the Aetna Select (Open Access) network prior to receiving services.*

Important Notes

Services received by providers or facilities **not** in the Aetna Select (Open Access) network, will not be covered.

Network	Aetna Select (Open Access)
Plan Year Deductible (PYD)	**In-Network**
Single	$1,500
Family	$3,000
Coinsurance	
Member Responsibility	0%
Plan Year Out-of-Pocket Limit	
Single	$3,500
Family	$7,000
What Applies to the Out-of-Pocket Limit?	Deductible, Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit *(No PCP Election Required)*	$25 Copay
Specialist Office Visit *(No Referral Required)*	$50 Copay
Telehealth Services	$25 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)**	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	0% After PYD
Outpatient Surgery in Surgical Center	0% After PYD
Physician Services at Surgical Center	0% After PYD
Urgent Care *(Per Visit)*	$50 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	0% After PYD
Outpatient Hospital *(Per Visit)*	0% After PYD
Physician Services at Hospital	0% After PYD
Emergency Room *(Per Visit; Waived if Admitted)*	$300 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	0% After PYD
Outpatient Services *(Per Visit)*	No Charge
Outpatient Office Visit	$25 Copay
Prescription Drugs *(Rx)*	
Generic	$10 Copay
Preferred Brand Name	$30 Copay
Non-Preferred Brand Name	$50 Copay
Mail Order Drug *(90-Day Supply)*	2x Retail Copay

Aetna POS II Plan At-A-Glance

Network	Aetna POS II (Open Access)	
Plan Year Deductible (PYD)	**In-Network**	**Out-of-Network****
Single	$500	$1,000
Family	$1,000	$2,000
Coinsurance		
Member Responsibility	20%	40%
Plan Year Out-of-Pocket Limit		
Single	$3,000	$6,000
Family	$6,000	$12,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$25 Copay	40% After PYD
Specialist Office Visit *(No Referral Required)*	$50 Copay	40% After PYD
Telehealth Services	$25 Copay	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)**	No Charge	40% After PYD
X-rays	No Charge	40% After PYD
Advanced Imaging *(MRI, PET, CT)*	$300 Copay	40% After PYD
Outpatient Surgery in Surgical Center	20% After PYD	40% After PYD
Physician Services at Surgical Center	20% After PYD	40% After PYD
Urgent Care *(Per Visit)*	$50 Copay	$50 Copay
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After PYD	40% After PYD
Outpatient Hospital *(Per Visit)*	20% After PYD	40% After PYD
Physician Services at Hospital	20% After PYD	40% After PYD
Emergency Room *(Per Visit; Waived if Admitted)*	$300 Copay	$300 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	20% After PYD	40% After PYD
Outpatient Services *(Per Visit)*	20% After PYD	40% After PYD
Outpatient Office Visit	$25 Copay	40% After PYD
Prescription Drugs *(Rx)*		
Generic	$10 Copay	50% Coinsurance
Preferred Brand Name	$30 Copay	50% Coinsurance
Non-Preferred Brand Name	$50 Copay	50% Coinsurance
Mail Order Drug *(90-Day Supply)*	2x Retail Copay	Not Covered

Locate a Provider

To search for a participating provider, contact Aetna's customer service or visit www.aetna.com. When completing the necessary search criteria, select **Aetna POS II (Open Access)** network.

Plan References

**LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Aetna. When using a lab other than LabCorp or Quest, please confirm they are contracted with the Aetna POS II (Open Access) network prior to receiving services.*

*****Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document..*

Aetna POS II with HSA Plan At-A-Glance

Locate a Provider

To search for a participating provider, contact Aetna's customer service or visit www.aetna.com. When completing the necessary search criteria, select **Aetna POS II (Open Access)** network.

Plan References

**LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Aetna. When using a lab other than LabCorp or Quest, please confirm they are contracted with the Aetna POS II (Open Access) network prior to receiving services.*

*****Out-Of-Network Balance Billing:**** *For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document.*

Network	Aetna POS II (Open Access)	
Plan Year Deductible (PYD)	**In-Network**	**Out-of-Network****
Single	$2,800	$5,400
Family	$5,400	$10,800
Coinsurance		
Member Responsibility	10%	40%
Plan Year Out-of-Pocket Limit		
Single	$4,000	$8,000
Family	$8,000	$16,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	10% After PYD	40% After PYD
Specialist Office Visit *(No Referral Required)*	10% After PYD	40% After PYD
Telehealth Services	10% After PYD	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)**	10% After PYD	40% After PYD
X-rays	10% After PYD	40% After PYD
Advanced Imaging *(MRI, PET, CT)*	10% After PYD	40% After PYD
Outpatient Surgery in Surgical Center	10% After PYD	40% After PYD
Physician Services at Surgical Center	10% After PYD	40% After PYD
Urgent Care *(Per Visit)*	10% After PYD	10% After PYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After PYD	40% After PYD
Outpatient Hospital *(Per Visit)*	10% After PYD	40% After PYD
Physician Services at Hospital	10% After PYD	40% After PYD
Emergency Room *(Per Visit; Waived if Admitted)*	10% After PYD	10% After PYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	10% After PYD	40% After PYD
Outpatient Services *(Per Visit)*	10% After PYD	40% After PYD
Outpatient Office Visit	10% After PYD	40% After PYD
Prescription Drugs *(Rx)*		
Generic	10% After PYD	50% After PYD
Preferred Brand Name	10% After PYD	50% After PYD
Non-Preferred Brand Name	10% After PYD	50% After PYD
Mail Order Drug *(90-Day Supply)*	10% After PYD	Not Covered

Health Savings Account

The Aetna POS II with HSA High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies enrollee to open Health Savings Account (HSA). An HSA is an interest-bearing account where funds may be used to help pay employee and dependent(s) deductible, coinsurance and any qualified medical expenses not covered by the plan.

2021-2022 Plan Year Funding:

- The City will fund each HSA Account $2,700 for 12 months.*
- The City funding is in addition to any voluntary amount funded.*

Employee may opt to fund an HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction; this decision must be made during Open Enrollment. Employee contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on employee's tax return (making such contributions tax-free).

- 2021 IRS Contribution Limitations: $3,600 (individual coverage) $7,200 (family coverage)
- 2022 IRS Contribution Limitations: $3,650 (individual coverage) $7,300 (family coverage)

Guidelines regarding the HSAs are established by the IRS.

Please Note: Individuals ages 55 and older can also make additional "catch-up" contributions up to $1,000 annually.

What to know about an HSA

- Employee owns the HSA funds from day one and decides how and when to spend the money.
- No use-it-or-lose it rules; funds are in the account when needed, now or in the future. Participant cannot fund a traditional Health Care FSA, however, participant may fund a Limited Purpose FSA for dental and vision expenses only.
- HSA funds earn interest.
- The HSA will be funded with employer contributions. If the employee desires to fund the remaining deductible balance they may do so with pre-tax payroll deductions.
- HSA dollars may be used tax-free for all eligible medical expenses.
- HSA funds are portable from one employer to another. Accumulated funds can help employee's plan for retirement.
- An account holder may write a check or withdraw funds with a Health Savings Account Debit Card.
- Some account service fees, determined by the bank, may apply.
- Account holder can access HSA statement at any time to track account balance and activity online at www.hsabank.com.
- To be eligible to open an HSA, employee must be covered by a high deductible health plan. Employee may not be covered under another medical plan that is not a high deductible health plan including a plan the employee's spouse may have selected where he/she has family coverage. Please Note: Eligibility status to qualify for an HSA is specifically driven by employee and NOT dependents.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in the employee's group insurance benefits as long as the dependent is a qualified tax dependent.
- Over-age dependent is not able to use HSA funds for qualified expenses, even if the dependent is covered under the medical plan as Federal law does not recognize them as a qualified dependent.
- If employee is enrolled in Medicare, TRICARE or TRICARE for Life, the employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits the City from contributing HSA funds into the account. If employee is not enrolled in Medicare, TRICARE or TRICARE for Life, then employee is eligible to enroll and contribute into the HSA up to the maximum contribution amounts.
- Active employee NOT on Medicare but with a spouse enrolled in Medicare: Any active employee who is covering a spouse that is enrolled in Medicare is eligible to enroll and contribute into the HSA up to the maximum contribution amounts. These funds can be utilized for the active employee and spouse expenses.
- Active employee ON Medicare and with a spouse NOT enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse may not contribute or receive any HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

**Please contact Employee Benefits Coordinator for further information regarding funding variations towards employer HSA contributions.*

HSA Bank | Customer Service: (800) 357-6246 | www.hsabank.com

Dental Insurance

Cigna DPPO Plan

The City offers dental insurance through Cigna to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Cigna's customer service.

Dental Insurance – Cigna DPPO Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0
Employee + Spouse	$7.23
Employee + Child(ren)	$10.50
Employee + Family	$17.76

In-Network Benefits

The DPPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open-access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Cigna Advantage network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Please Note: *Members have the option to utilize a dentist that participates in either Cigna's Advantage network or DPPO network. However, members that use the Cigna Advantage network will see additional cost savings from the added discount that is allowed for using an Advantage network provider. Members are responsible for verifying whether the treating dentist is an Advantage Dentist or a DPPO Dentist.*

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Cigna Advantage provider. Cigna reimburses out-of-network services based on what it determines as the Maximum Reimbursable Charge (MRC). The MRC is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between the Cigna's MRC and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The DPPO plan requires a $50 individual or a $100 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the DPPO plan will pay for each covered member is $1,500 for in-network and out-of-network services combined. All services, including preventive services, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

Cigna Dental WellnessPlus

When employee or employee family members receive any preventive care service in one plan year, the annual benefit maximum will increase in the following calendar year. When employee and employee family members remain enrolled in the plan and continue to receive preventive care, the annual benefit maximum will increase in the following calendar year, until it reaches the level specified below. Please refer to your plan materials for additional information on this plan feature.

Year 1: Benefit maximum $1,500

Year 2: Benefit maximum will increase to $1,600 contingent upon receiving Preventive Services in Plan Year 1

Year 3: Benefit maximum will increase to $1,700 contingent upon receiving Preventive Services in Plan Years 1 and 2

Year 4 and beyond: Benefit maximum will increase to $1,800 contingent upon receiving Preventive Services in Plan Years 1, 2 and 3

Cigna | Customer Service: (800) 244-6224 | www.mycigna.com

Cigna DPPO Plan At-A-Glance

Network	Advantage	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$100	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,500**	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(1 Every 6 Months)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(1 Every 6 Months)*		
Bitewing X-rays *(2 Sets Per Calendar Year)*		
Class II Services: Basic Restorative Care		
Complete X-rays *(1 Per 36 Months)*	Plan Pays: 90% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Fillings		
Simple Extractions		
Endodontics *(Root Canal Therapy)*		
Oral Surgery		
Periodontal Services		
Anesthetics		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 60% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Bridges		
Dentures		
Implants		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,500	
Benefit *(Dependent Child(ren) Up To Age 19)*	Plan Pays: 50% Deductible Waived	Plan Pays: 50% Deductible Waived *(Subject to Balance Billing)*

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select **Advantage** network.

Plan References

Out-Of-Network Balance Billing:
For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Out-of-Network Benefits section on the previous page.

****Cigna Dental Wellness Plus:***
When employee and dependent remain enrolled in the plan and continue to receive preventive care, the calendar year benefit maximum will increase in the following year.

Important Notes

- *Each covered family member may receive up to two (2) routine cleanings per calendar year covered under the preventive benefit.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of your dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

Vision Insurance

EyeMed Vision Care Plan

The City offers vision insurance through EyeMed to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to the carrier's summary plan document or contact EyeMed's customer service.

Vision Insurance – EyeMed Vision Care Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0
Employee + Family	$2.22

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employee and covered dependent(s) can select any network provider who participates in the EyeMed Select network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Employee and covered dependent(s) may choose to receive services from vision providers who do not participate in the EyeMed Select network. When going out of network, the provider will require payment at the time of appointment. EyeMed will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

EyeMed | Customer Service: (866) 939-3633 | www.eyemed.com

EyeMed Vision Care Plan At-A-Glance

Network		Select	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$5 Copay	Up to $18 Reimbursement
Contact Lens Fit & Follow-Up	Standard Lens	Up to $40 Allowance	Not Covered
	Premium Lens	10% Off Retail Price	Not Covered
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		12 Months	
Contact Lenses		12 Months	
Lenses			
Single		$10 Copay	Up to $13 Reimbursement
Bifocal		$10 Copay	Up to $23 Reimbursement
Trifocal		$10 Copay	Up to $40 Reimbursement
Standard Progressive Lenses		$70 Copay	Up to $25 Reimbursement
Premium Progressive Lenses		$70 Copay; Plus 20% Discount Off Balance Over $120	Up to $25 Reimbursement
Frames			
Allowance		$110 Retail Allowance; Then 20% Discount Off Balance Over $110	Up to $55 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		No Charge	Up to $200 Reimbursement
Elective *(Lenses)*	Conventional:	$120 Allowance; Then 15% Discount Off Balance Over $120	Up to $96 Reimbursement
	Disposable:	$120 Allowance; Plus Balance Over $120	Up to $96 Reimbursement

Locate a Provider

To search for a participating provider, contact EyeMed's customer service or visit www.eyemed.com. When completing the necessary search criteria, select **Select** network.

Plan References

**Contact lenses are in lieu of spectacle lenses and a frame.*

Important Notes

Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.

Flexible Spending Accounts

The City offers Flexible Spending Accounts (FSA) administered through P&A Group. The FSA plan year is from October 1 to September 30.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employee to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from employee's paycheck and deposited into the FSA. During the year, employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount to be deducted each plan year. There are three (3) types of FSAs:

The City offers Health Care FSA, Limited Purpose FSA, and Dependent Care FSA.

- **Health Care FSA:** Available to eligible employees who are **not** enrolled in the Aetna POS II with HSA High Deductible Health Plan (HDHP). The Health Care FSA covers medical, dental, and vision expenses that are not paid by insurance.
- **Limited Purpose FSA:** Available to eligible employees who are enrolled in the Aetna POS II with HSA High Deductible Health Plan (HDHP). A Limited Purpose Health Care FSA may be used for qualified dental and vision expenses.
- **Dependent Care FSA:** Covers day care expenses for qualified dependents in order for employee and legal spouse to work.

Health Care FSA

This account allows participant to set aside up to an annual maximum of $2,750. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of $5,000 if single or married and file a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

Please note, if family income is over $20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return. To qualify, dependents must be:

- A child under the age of 13, or
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least eight (8) hours a day in the participant's household.

Please Note: Unlike the Health Care FSA, reimbursement is only up to the amount that has been deducted from participant's paycheck for the Dependent Care FSA.

A sample list of qualified expenses eligible for reimbursement include, but not limited to, the following:

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

Log on to http://www.irs.gov/publications/p502/index.html for additional details regarding qualified and non-qualified expenses.

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- Employee may carry over a minimum of $100 up to $550 of unused Health Care FSA funds into the next plan year after a plan year ends and all claims have been filed (only if the employee re-enrolls the next year). Dependent Care funds cannot be carried over.
- The Health Care FSA has a run out period at the end of the plan year (90 days) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year.
- When a plan year ends and all claims have been filed with the exception of the $550 rollover for the Health Care FSA, all unused funds will be forfeited and not returned.
- Employee can enroll in either or both of the FSAs only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility period.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail or fax. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. P&A Group may request supporting documentations for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the City. Please keep the issued card for the next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $38.46 based on a 26 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $197.

	With a Health Care FSA	Without a Health Care FSA
Salary	$30,000	$30,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$29,000	$30,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- $5,698	- $5,895
After Tax Expenses	- $0	- $1,000
Spendable Income	$23,302	$23,105
Tax Savings	**$197**	

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year with the exception of the $550 carry over that may be allowed for the Health Care FSA.* ***This rule is known as "use-it or lose-it."***

P&A Group | Phone: (800) 688-2611 | www.padmin.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City provides Basic Term Life insurance for all eligible employees at no cost through New York Life. Eligible employees will receive a benefit amount of one (1) times annual salary up to a maximum of $75,000.

Life Insurance Imputed Income

The IRS requires the imputed cost of employer paid Employee Life insurance benefit in excess of $50,000 must be included in income and is subject to Federal, Social Security and Medicare taxes.

Accidental Death & Dismemberment Insurance

Also, at no cost to employee, the City provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit, partial benefits may also be payable.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- Reduces to 65% of the benefit amount at age 65
- Reduces to 50% of the benefit amount at age 70

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through Bentek.

New York Life Group Benefit Solutions
Customer Service: (800) 362-4662 | www.mynylgbs.com

Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

Eligible employee may elect to purchase additional Life insurance on a voluntary basis through New York Life. This coverage may be purchased in addition to the Basic Term Life and AD&D coverages. Voluntary Life Insurance offers coverage for employee, spouse and/or child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $130,000**.

- Units can be purchased in increments of $10,000, but cannot exceed the lesser of five (5) times annual salary or $500,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70

For 2021-2022 Open Enrollment:

- If employee did not initially apply for Voluntary Employee Life insurance during the new hire eligibility period, employee may enroll up to the Guaranteed Issue amount of $130,000 without Evidence of Insurability (EOI) application.
- If employee currently has Voluntary Employee Life insurance, the employee will have the option to increase their coverage by increments of $10,000, not to exceed the Guaranteed Issue amount of $130,000.

Voluntary Spouse Life Insurance

New Hires may purchase Voluntary Dependent Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $30,000.**

- Employee must participate in the Voluntary Employee Life plan for dependent(s) to participate.
- Units can be purchased in increments of $10,000 up to a maximum of $250,000 but not to exceed 100% of employee's basic and voluntary coverage amount.

2021-2022 Open Enrollment:

- If employee did not initially apply for Voluntary Spouse Life insurance during the new hire eligibility period, employee may enroll the spouse up to the Guaranteed Issue amount of $30,000 without Evidence of Insurability (EOI) application.
- If employee currently has Voluntary Spouse Life insurance, the employee will have the option to increase the spouse coverage by increments of $10,000, not to exceed the Guaranteed Issue amount of $30,000.
- Employees may increase coverage for employee and spouse up to an additional amount of $10,000 not to exceed the Guarantee Issue amount of $130,000 without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI). Please contact Employee Benefits Coordinator for additional information.

Voluntary Child(ren) Life Insurance

- Coverage may be purchased for dependent child(ren) from 14 days to six (6) months in the amount of $500.
- Coverage may be purchased for dependent child(ren) from six (6) months until the child reaches age 19 (or under age 30 if full-time students) in the amounts of $5,000 or $10,000.
- Rate: $5,000 is $.75 and $10,000 is $1.50.

Voluntary Life and AD&D Insurance *(Continued)*

Voluntary Family Benefit Option 1

- For legal spouses, there is a $10,000 benefit amount.
- For child(ren) 15 days to six (6) months, there is a $1,000 benefit amount.
- For child(ren) six (6) months to 19 years (up to 30 years of age, if unmarried and a full-time student) there is a $5,000 benefit amount.
- Coverage is a family rate of $2.24 per family unit per month.

Voluntary Family Benefit Option 2

- For legal spouses, there is a $5,000 benefit amount.
- For child(ren) 15 days to six (6) months, there is a $1,000 benefit amount.
- For child(ren) six (6) months to 19 years (up to 30 years of age, if unmarried and a full-time student) there is a $2,000 benefit amount.
- Coverage is a family rate of $1.05 per family unit per month.

Please Note: *Employees may choose either the Voluntary Family Benefit Option 1 or the Voluntary Family Benefit Option 2, but not both.*

New York Life Group Benefit Solutions
Customer Service: (800) 362-4662 | www.mynylgbs.com

Short Term Disability

The City offers two (2) options for Short Term Disability (STD) insurance to all eligible employees through New York Life. The STD benefit pays a percentage of employee's weekly earnings if they become disabled due to an illness or non-work related injury.

Short Term Disability (STD) Benefits
Option 1 - Employer Paid

- The STD program offers a benefit of 66.67% of weekly earnings up to a benefit maximum of $1,000 per week.
- Employee must be sick or injured for 30 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will commence on the 31st day of illness or nonwork related injury.
- The maximum benefit period is 26 weeks.
- Benefits may be reduced by other income.
- Disability benefits are taxable.

Short Term Disability (STD) Benefits
Option 2 - Employee Paid

- The STD program offers a benefit of 66.67% of weekly earnings, subject to a maximum of $1,000 per week.
- An employee must be sick or injured for seven (7) days prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will commence on the 8th day for accident or illness.
- The maximum benefit period is 26 weeks.
- Benefits may be reduced by other income.
- Disability benefits are taxable.

New York Life Group Benefit Solutions
Customer Service: (800) 362-4662 | www.mynylgbs.com

Voluntary Long Term Disability

The City offers Long Term Disability (LTD) insurance to all eligible employees through New York Life. The LTD pays a percentage of monthly earnings if employee becomes disabled due to an illness injury.

Voluntary Long Term Disability (LTD) Benefits

- The LTD program offers a benefit of 60% of monthly earnings, subject to a maximum of $10,000 per month.
- Employee must be disabled for 180 days prior to becoming eligible for benefits.
- Benefit payments will commence on the 181st day of disability.
- Employee may continue to be eligible for benefits if employee returns to work on a part-time basis.
- The maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income.

New York Life Group Benefit Solutions
Customer Service: (800) 362-4662 | www.mynylgbs.com

Employee Assistance Program

The City cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Cigna Behavioral Health. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes three (3) face-to-face, visits with a specialist, per person, per issue per year, telephonic consultation, online material/tools and webinars. EAP offers counseling services on issues such as:

- ✓ Child Care Resources
- ✓ Legal Resources
- ✓ Grief and Bereavement
- ✓ Stress Management
- ✓ Depression and Anxiety
- ✓ Work Related Issues
- ✓ Adult & Elder Care Assistance
- ✓ Financial Resources
- ✓ Family and/or Marriage Issues
- ✓ Substance Abuse

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor/manager, we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor/manager will not receive specific information regarding the referred employee's case. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

To Access Services

Employee and family member(s) may pre-register and create a user ID on www.mycigna.com to access EAP services.

Cigna Behavioral Health | Customer Service: (877) 622-4327
www.mycigna.com | Employer ID: northport

Supplemental Insurance

Trustmark

Trustmark offers voluntary supplemental insurance plans that may be purchased separately, on a voluntary basis, and premiums paid by payroll deduction. To learn more about these Trustmark plans and/or to schedule a personal appointment, contact SimplEnroll. Available plans include:

- Accident Plan - with Wellness Rider
- Critical Illness/Cancer Plan
- Universal Life with Long Term Care

Trustmark | Customer Service: (888) 254-1093
www.trustmarksolutions.com

Transamerica

Transamerica offers a voluntary, supplemental Hospital Indemnity insurance plan that may be purchased separately and premiums paid by payroll deduction. A brief summary of benefits and the bi-weekly rates for coverage are listed in the tables below. To learn more about the Transamerica Hospital Indemnity plan and/or to schedule a personal appointment, contact SimplEnroll.

Summary of Benefits	
Hospital Confinement Benefit Pays each day a covered person is confined to a hospital for a minimum of 24 hours from admission	$1,000 **Maximum:** 1 Day Per Confinement/ 1 Day Per Calendar Year
Daily-In Hospital Benefit Pays each day a covered person is confined to a hospital	$200.00 Per Day **Maximum:** 31 Days Per Confinement
Surgical & Anesthesia Benefit	
Inpatient Surgery	$1,000
Outpatient Surgery	$500
Outpatient Minor Surgery	$100
Anesthesia	30% Of Surgical Benefit
Bi-Weekly Deductions	
Employee	$10.44
Employee & Spouse	$22.89
Employee & Child(ren)	$17.73
Family	$27.72

Transamerica | Customer Service: (888) 254-1093
www.transamericaemployeebenefits.com

Identity Theft Plan

LifeLock Identity Theft Protection

LifeLock offers two (2) Identity Theft protection plans to employees, LifeLock Benefit Elite and LifeLock Ultimate Plus on a voluntary basis

LifeLock Benefit Elite includes the following services:

- LIfeLock Identity Alert System
- Lost Wallet Protection
- Address Change Verification
- Black Market Website Surveillance
- LifeLock Privacy Monitor Tool
- Reduced Pre-Approved Credit Card Offers
- Live Member Service Support
- Identity Restoration Support
- Fictitious Identity Monitoring
- Court Records Scanning
- Data Breach Notifications
- Investment Account Activity Alerts
- $1 Million Service Guarantee

LifeLock Ultimate Plus includes the above services plus the following:

- Credit Card, Checking & Savings with Account Activity Alerts
- Online Annual Credit Report
- Online Annual Credit Score
- Checking and Savings Account Application Alerts
- Bank Account Takeover Alerts
- Credit Inquiry Alerts
- Online Annual Tri-Bureau Credit Reports & Scores
- Monthly Credit Score Tracking
- File-Sharing Network Searches
- Sex Offender Registry Reports
- Priority Live Member Service Support

Tier of Coverage	LifeLock Benefit Elite	LifeLock Ultimate Plus
Employee Only	$3.92	$11.76
Employee + Spouse	$7.84	$23.53
Employee + Child(ren)	$6.86	$16.67
Employee + Family	$10.78	$28.44

LifeLock | Customer Service: (800) 543-3562 | www.lifelock.com

Pet Insurance

Nationwide Pet Insurance

The City offers employees the opportunity to purchase voluntary pet insurance through Nationwide Pet Insurance. Pet insurance plans cover medical treatments and surgeries for accidents, illnesses, and medical conditions which range from minor problems such as ear infections and bee stings, to major conditions such as broken bones, diabetes and cancer. To learn more about pet insurance, visit the Nationwide Pet Insurance online at www.petinsurance.com/cityofnorthport.

Enrollment and premium payment arrangements may also be made online. Nationwide Pet Insurance representatives can be contacted by phone at (877) 738-7874.

Nationwide Pet Insurance | Customer Service: (877) 738-7874
www.petinsurance.com/cityofnorthport

Retiree Benefits

Group Retiree Health Plan

The City's Group Retiree Health Plan will be provided by the insurance carrier(s) in force at the time of retirement and is subject to change if the City changes carriers, benefits or rates. All of the following requirements must be met in order for a City employee to be eligible for retiree insurance benefits (medical, dental & vision insurance).

- Employees must have a minimum of eight (8) years of service vested with the City in conjunction with the Florida Retirement System (FRS).
- The employee must be eligible to receive and/or be receiving benefits from the FRS.
- Retirement age of 62 or above must be attained (unless the employee has 30 consecutive years of service with the FRS/25 Years for High Risk employees).
- Having a job elsewhere is not a factor
- Retirees may only change from one health plan to another and/or lower tier coverage on Health, Dental or Vision. Retirees may not add or increase coverage.

Group Retiree Health Plan Rates

Tier of Coverage	Aetna Select Plan	Aetna POS II	Aetna POS II with HSA Plan*
Employee Only	$695.39	$698.24	$674.91
Employee + Spouse	$1,405.87	$1,411.79	$1,380.62
Employee + Child(ren)	$1,279.69	$1,285.06	$1,255.27
Employee + Family	$2,136.25	$2,145.28	$2,106.07

Please Note: **If you are Medicare, TRICARE or TRICARE for Life eligible or you have other coverage, you may be able to enroll in the HDHP but not contribute to an HSA. Review your options before enrolling.*

Tier of Coverage	Dental
Employee Only	$35.38
Employee + Spouse	$67.05
Employee + Child(ren)	$81.39
Employee + Family	$113.20

Tier of Coverage	Vision
Employee Only	$3.47
Employee + Spouse	$12.23
Employee + Child(ren)	$12.23
Employee + Family	$12.23

Notes

Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctors' names and addresses or prescription medications.

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NorthPort SM
FLORIDA

GEHRING® GROUP
EMPLOYEE BENEFITS | RISK MANAGEMENT

3500 Kyoto Gardens Drive
Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696 | Fax: (561) 626-6970
www.gehringgroup.com

FINAL
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